STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A0000	This visit was for a State hospital licensure survey. Dates: 6/27/2011 thrugh 6/29/2011 Facility Number: 005066 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 07/25/11	A0000	Dear Ms. Hamel, Thank you for the opportunity to respond to the deficiencies noted during our survey. Attached you will find our response to the deficiencies from the survey of June 29, 2011. Included in this packet is the "Statement of Deficiencies and Plan of Correction" signed by our Chief Executive Officer as well as additional documentation supporting the plan outlining corrective actions taken. We believe that this plan and supporting documentation demonstrate our compliance with the findings. Should you have any additional questions or comments, please do not hesitate to contact me. I look forward to a notice from your office that this issue is resolved. Sincerely, Sandra Wildermuth, BS CHCCompliance and Risk OfficerPhone: 574-753-1767swildermuth@logansportmemorial.org	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A0278	410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D) (b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially; (C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and (D) this process occurs within a reasonable period of time, as specified by the medical staff bylaws. Based on document review, the facility failed to ensure 3 of 3 allied health workers appointed to the medical staff with granted clinical privileges. (M11, M12, and M13) Findings included: 1. The Governing Board By-laws 1.3 Application for initial appointment and clinical privileges states, "Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the Board upon recommendation of the Credential Committee. These forms shall obtained from the office of the President or a	A0278	In response to tag A 278, we performed the following:a. Evaluated our credentialing processb. Prepared the "Advanced Nurse Practitioner Collaborative Practice Agreement" detailing the core privileges.c. On August 23, 2011 the Credentialing Committee meets and will review each previously credentialed Nurse Practitioner's core privileges.d. Each NP's agreement will be signed off by all appropriate parties.e. The President & CEO is responsible for ensuring each Nurse Practitioner's core privileges are reviewed through Credentialing Committeef. Attachment A: Advanced Nurse Practitioner	08/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	designee. The application shall contain a request for the staff category and specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including...." 2. Credentialed files were reviewed on 6/27 and of the 13 credentialed staff selected for review, three were Nurse Practitioners (M11, M12, and M13). The staff members' credentialed files lacked granted clinical privileges based on their professional training. 3. Staff members #1 and #3 confirmed the allied health workers did not have granted clinical privileges as required by the Medical Staff.		Collaborative Practice Agreement form	
A0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, document review and interview, the facility failed to ensure chemical Cidex Plus was used per manufacturer instructions on health care equipment that comes in direct contact with patients for the Ultrasound in Radiology, failed to date open medication	A0554	Within tag S 0554 there are five (5) different issues to address.I. Cidex Plus used in Radiology's Ultrasound department. a. Mike Etter (Director Ancillary Services) and Terri Reynolds (Ultrasonographer), reviewed all MSDS, package inserts and on-line information available for	08/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bottles and discard expired medication bottles, failed to ensure 3 of 3 crash carts checked were free of outdated supplies and that the ambulatory surgical area was kept in a clean, sanitary manner, and the correct cleaning product was used according to manufacturer's directions. Findings included: 1. The hospital was using advanced sterilization product (Cidex Plus), high level disinfectant for semi-critical devices such as the ultrasound. Cidex Plus manufacturer sheet requires: 1) activate the Cidex Plus by adding the entire contents of the Activator Vial which is attached to the gallon container, 2) Test the activated solution prior to use with Cidex Plus test strips, 3)thoroughly clean, rinse, and rough dry devices before immersing in Cidex Plus cleaning solution, 4) medical devices should be rinsed with sterile water, using aseptic technique when rinsing and handling. Warning: the use of potable water increases the risk of recontaminating medical devices with waterborne organisms, and 5) personal protective equipment (PPE) includes gloves appropriate type and length, eye protection, face mask, and fluid-resistant gowns or aprons.		the use of CIDEX PLUS. This information was then used to establish the following: 1. Attachment A: New policy for the safe handling and usage of CIDEX PLUS 2. Attachment B: New record keeping process (Log) for QC and disposal of CIDEX PLUS 3. Attachment C: New training with competency/validation verification (Mike Etter and Terri Reynolds as designated validators) 4. Remaining Ultrasonographers (Margo Liebner and Amanda Troyer) were trained and validated on Thursday, June 30, 2011.Annual education/competency testing for Ultrasonographers. Documented in the Cidex Plus logbook. 5. Audit findings will be reported quarterly to the Infection Control Committee.II. Expired product found in various locations. a. Lori Sylvester, Infection Control Coordinator developed a tool to audit for outdated supplies and medications. Daily, the Crash cart will be checked to verify supplies on the cart are not outdated and they are all present. The lock will be checked on the cart and respiratory box. The Defibrillator will be unplugged and “Tested” to ensure the battery is charged. Monthly, the Crash cart will be opened and supplies and medications will be checked for outdates and replaced. The lock will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. At 11:10 AM on 6/27/2011, the ultrasound in radiology was inspected. It was observed Cidex Plus high level disinfectant was used for disinfecting the probes. 3. Staff member #14 explained the procedure on how the chemical was used and prepared. The staff member indicated he/she does not have test strips to test the solution because after mixing the reagent with Cidex Plus, the solution should be at the proper strength as required. The staff member indicated he/she only utilizes latex gloves when preparing the solution. The staff member rinses the probe off by running it under the faucet of the hand washing sink. 4. The facility does not have test strips to measure the solution after it was activated as per the manufacturer requirements. The room did not have appropriate gloves, face mask, and appropriate apron or gown for the PPE needed as required by the manufacturer's instruction. 4. At 11:20 AM on 6/27/2011, the Fluoroscopic Room was inspected. An over the counter cabinet contained an open bottle of 30 ml of Bacteriostatic 0.9% sodium chloride which expired January 2009. The cabinet also contained 2-500 ml sodium chloride which also		reapplied to cart. b. Attachment D: Daily Crash Cart Checklist c. Attachment E: Monthly Audit Tool for Outdated Supplies/Medications including first month audit findings. d. Audit findings will be reported quarterly to the Infection Control Committee.III. Environmental Services staff is not using cleaning products in accordance with kill time of product.a. Lori Sylvester, Infection Control Coordinator reviewed the products available and determined Memorial Hospital will transition from Green Earth or Fight Bac RTU products to PDI for disinfectant use for high touch, hard surface disinfection which has a 2 minute kill time. 1. Removal of Green Earth and Fight Bac RTU will be completed by August 31, 2011.2. In-Service training on new product will be completed by August 31, 2011.3. Attachment F: Product Information sheet4. Attachment G: In-Service Objectives5. Attachment H: In-Service Sign In sheetsIV. 410 IAC 1-5-36 Work EnvironmentPlease see IDR Record filed.V. Dust found on carts and wall ledges.Lori Sylvester, Infection Control Coordinator worked with Jerry Snow, Environmental Services Coordinator to review current process and develop an new process.1. Attachment I - Dusting carts and wall ledges was added to work schedule 1072.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	expired May 2006. One of the two bottles were open and half of the solution was used. The bottle lacked an open date. 5. Staff member #2 verified the outdated product. 6. During the tour of the emergency department, beginning at 12:25 PM on 06/28/11, and accompanied by staff members N1, N2, and N10, the following observations were made: A. Two of two blue top lab tubes with an expiration date of 05/2011 on the pediatric crash cart. B. Two of two red top lab tubes with an expiration date of 05/2011 on the pediatric crash cart. C. Two of two defibrillator electrodes with an expiration date of 05/28/2011 on the pediatric crash cart. 7. At 12:35 PM on 06/28/11, staff member N10 was observed cleaning a patient cart with a spray bottle of Green Earth Daily Disinfectant Cleaner Spray. Staff member N10 indicated he/she sprayed the disinfectant, left it on for a couple of minutes, then wiped it off. Review of the manufacturer's directions indicated a 10 minute contact time was required for complete effectiveness. The label and manufacturer's literature		Attachment J - Environmental Staff trained on dusting requirements3. Audit of cleaning process will be reported to Infection Control on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided failed to indicate the product was a tuberculocidal. 8. At 10:15 AM on 06/29/11, the infection control nurse, staff member N25, indicated he/she thought a tuberculocidal product only had to be used for blood or other body fluid clean-up. 9. 410 IAC 1-5-36 Work Environment, ..."(h) Disinfectant solutions shall be: (1) a hospital grade, tuberculocidal Environmental Protection Agency (EPA) registered disinfectant; or (2) sodium hypochlorite, five-tenths percent (0.5%) concentration, by volume (common household bleach in ten percent (10%) concentration in water); the solution shall be dated and shall not be used if it is more than twenty-four (24) hours old." 10. During the tour of the surgical department, beginning at 1:10 PM on 06/28/11, and accompanied by staff members N1, N3, and N21, the following observations were made: A. Three of three 100 milliliter bags of 5% Dextrose with an expiration date of 1 June 2011 in the adult crash cart. B. The bottoms of the patient carts in ambulatory surgery had a heavy coat of dust. C. The wall ledges in the patient cubicles			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in ambulatory surgery had a layer of dust. 11. During the tour of the medical-surgical department, beginning at 3:05 PM on 06/28/11, and accompanied by staff members N1, N3, and N22, the following observations were made: A. One of one 100 milliliter bag of 5% Dextrose with an expiration date of 1 June 2011 in the adult crash cart. B. One of one defibrillator pads with an expiration date of 04/2011 in the adult crash cart.	S0554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A0610	410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation and document review, the facility failed to ensure 5 of 5 kitchen staff workers were trained on diseases and infections that are trained through food and the facility failed to ensure proper hand washing was ensured throughout the kitchen and the cafe. Findings included: 1. Retail Food Establish Sanitation	A0610	Within tag A 0610 there are 3 different issues to address.I. Review for illness and infections transmittable through food of newly hired kitchen staffa. The Infection Control Coordinator and the V.P. Human Resources developed a new process for use during the hiring process for each new kitchen staff employee.b. Each newly hired employee goes through our pre-employment health screen. During this screen the nurse will review the	08/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Requirements 410 IAC 7-24-120 states, "The owner or operator of a retail food establishment shall require food applicants to whom a conditional offer of employment was made and food employees to report to the person-in charge information about their health and activities as they relate to diseases that are transmittable through food."" 2. The personnel files for staff members A2, A3, A4, A9, and A10. None of the personnel files noted any documentation that the staff were trained as required by 410 IAC 7-24-120. 3. This was confirmed by Staff member #17. 4. Retail food establishment Sanitation Requirements 410 IAC 7-24-129 states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms, (2) After using the toilet room, (3) After caring for or handling service animals or aquatic animals, (4)		Nutritional Department Employee Reportable Symptoms and Conditions form (Attachment A) with the new employee to determine if the employee currently has an illness or infection that is transmittable through food and to train the employee on his/her requirement to report these to their supervisor.II. Training of kitchen workers on reporting of personal illnesses and infections transmittable through food. An In-Service education process was developed by the Infection Control Coordinator for use immediately and then annually.a. Attachment B: In-Service Objectivesb. Attachment C: In-Service Directionsc. Attachment D: In-Service PowerPointd. Attachment E: In-Service QuizIII. Hand-washing education for kitchen workersa. The Infection Control Coordinator developed education materials for the kitchen staff and a work order was submitted for placement of a sink.b. A sink will be installed in the food service area.c. Attachment F: Action plans for Hand Hygiened. Attachment G: Education Materialse. Attachment H: Quizf. Attachment I: Weekly Validation Toolg. Attachment J: Work Order for sink placementh. The results of the weekly validation will be presented to the Infection Control Committee monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	After coughing, sneezing, or using a handkerchief or disposable tissue, (5) After drinking, other than as specified in section 113(b) of this rule, using tobacco, or eating, (6) After handling soiled surfaces, equipment, or utensils, (7) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, (8) When switching between working with raw food and working with ready-to-eat food, (9) Before touching food or food-contact surfaces, (10) Before placing gloves on hands, and (11) After engaging in other activities that contaminate the hands." 5. The hospital had posted in the kitchen a sign stating, "When must I wash my hands? - Before applying plastic gloves." 6. At 9:30 AM on 6/27/2011, The Cafe Express coffee shop was toured. Staff member #9 was observed cleaning an utensil then a customer approached and asked for a pastry in the pastry case. The staff member was observed putting on gloves without washing hands first then reached in with the gloved hands and handled the pastry and placed it on a paper plate. 7. At 12:15 PM on 6/27/2011, the main			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	kitchen and cafeteria was toured. A member behind the serving line was observed wiping their gloved hands on their apron and then handled a bun with the same gloved hand when preparing a hamburger for a customer. At least 6 other staff members throughout the kitchen were observed changing gloves without washing their hands first. During the tour of the kitchen, not one staff member was observed washing their hands but changed gloves which were located near all work areas.			
A0674	410 IAC 15-1.5-3(f) (f) If sufficient or suitable outside facilities are not provided by undertakers or others, the hospital shall have a morgue or a low temperature body holding room. Policies covering appropriate refrigeration requirements and length of holding bodies shall be approved by the medical staff. If autopsies are performed in the hospital, there shall be a refrigerated storage unit designed for holding bodies, along with hand washing facilities and other necessary personal hygiene facilities available. Based on observation, document review, and interview, the facility failed to ensure the body holding refrigerator temperature was being monitored in the walk-in	A0674	TAG A 0674Jeanette Huntoon, Chief Executive Nurse, Tara McVay, Director of Nursing and Dave Brumett, Manager of Facility Services reviewed the	08/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Morgue Body Holding Refrigerator. Findings included: 1. Morgue Refrigeration policy for temperature control states, "Please date, time, and initial each time this refrigerator is used. Also record temperature. Temperature should read between 1.1 c and 4.4 c after it has been on for 10 minutes." 2. The Morgue Refrigeration logs were reviewed for 2011. The logs had 26 entries starting 1/5/2011 and ending 6/8/2011. Recorded on the Temperature line had 18 other entries but not the required recorded temperature of the refrigerator. The log had 10 recorded temperature entries as "turned on" or "on"; 5 recorded temperature entries as 'turned off" or "off"; and three temperature entries had no temperature recorded at all. One of the 26 recorded date entries had a temperature of 5 c which was out of the required temperature range. After reviewing the temperature logs, it could not be determined when bodies were placed in the holding refrigerator. 3. At 2:00 PM on 6/28/2011, staff member #1 indicated the hospital does not keep any log or documentation of bodies that are placed in the Morgue's Body		survey findings and developed a new process to ensure the refrigerator temperature is monitored. We have installed a monitor in the morgue programmed with an acceptable temperature range. The monitor will alarm if the temperature goes outside that range.The morgue log was revised and education is being performed with the Resource Coordinators and Coroners.a. Attachment A: Revised policy and logb. Attachment B: Sample morgue temperature log	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Holding Refrigerator; therefore, he/she could not determine when bodies were placed in the refrigerator.			
S0744	410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on policy review, medical record review, and interview, the facility failed to ensure all entries in the medical record were legible and complete and errors were corrected according to policy in 13 of 19 closed patient records reviewed (#P1, P3, P4, P5, P7, P8, P10, P11, P12, P13, P14, P15, and P16). Findings included: 1. Review of the facility policy titled Charting Procedure, dated November 2008, indicated, ..."5. Errors are crossed off neatly (one line through entry) with error written above it. Then you must initial and date it. The mistake should be readable." 2. The medical record for patient #P1 had entries written over/changed on the Assessment and Checklist, Post-Operative Information, and Post Anesthesia Recovery Record from 02/18/11.	S0744	The survey findings for tag S 744 included entries that were incomplete, illegible and with errors corrected in a manner not in accordance with our policy. Malinda Wyatt, Director of Medical Records and Tara McVay, Director of Nursing reviewed our current policy/process and determined that education and monthly audits must be done. Each department is educating staff during their department meetings and a presentation will be given to the physicians during Primary Care and Surgery Sections. The audit findings will be reported to the Medical Record Committee and to the Quality Committee. Attachment A: Action Plan for documentation completeness and error correction Attachment B: Nursing Policy/Process Attachment C: Department Education Sign In sheets Attachment D: Monthly audit tool.	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. The medical record for patient #P3 had entries written over/changed on the Doctor's Orders and Progress Notes, Post Anesthesia Recovery Record, and Pediatric Medication Administration Record from 02/23/11. 4. The medical record for patient #P4 had entries written over/changed on the Post Anesthesia Recovery Record from 12/10/10 and the Medication Administration Record from 12/11/10. 5. The medical record for patient #P5 had entries written over/changed on the Doctor's Orders and Progress Notes, Pre-Anesthesia Evaluation, and Post Anesthesia Recovery Record from 12/20/10. 6. The medical record for patient #P7 had entries written over/changed on the Doctor's Orders and Progress Notes from 01/25/11. 7. The medical record for patient #P8 had entries written over/changed on the Perioperative Nursing Care Plan and the Post Anesthesia Recovery Record from 01/25/11 and the Blood Transfusion Form and the Medication Administration Record from 01/23/11. 8. The medical record for patient #P10			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had entries written over/changed on the Blood Transfusion Form from 03/16/11 and the Discharge Summary Sheet from 03/17/11. 9. The medical record for patient #P11 had entries written over/changed and scribbled out on the Blood Transfusion Records from 12/21/10 and 12/22/10, the Emergency Department Doctor's Orders from 12/21/10, the Minor Procedure Record from 12/24/10, the Doctor's Orders and Progress Notes from 12/24/10, and the Discharge Summary Sheet from 12/25/10. 10. The medical record for patient #P12 had entries written over/changed on the Emergency Department Order Sheet and the Emergency Department Record from 02/13/11. 11. The medical record for patient #P13 had entries written over/changed and scribbled out on the Emergency Department Doctor's Orders from 02/24/11, the Doctor's Orders and Progress Notes from 02/24/11, and the Blood Transfusion Record from 02/25/11. 12. The medical record for patient #P14 had entries written over/changed and scribbled out on the Post Anesthesia Recovery Record and the Medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administration Record from 12/30/10 and the Blood Transfusion Record from 01/01/11. 13. The medical record for patient #P15 had entries written over/changed on the Doctor's Orders and Progress Notes and the Labor and Delivery Summary Record from 03/25/11. 14. The medical record for patient #P16 had entries written over/changed and scribbled out on the Emergency Department Order Sheet from 04/14/11, the Hourly Rounding Log from 04/15/11, and the Medication Administration Record from 04/14/11 and 04/15/11. 15. At 2:00 PM on 06/29/11, staff member N1 confirmed these medical record findings.			
S0748	410 IAC 15-1.5-4 (e)(3) (e) All entries in the medical record shall be: (3) authenticated and dated promptly in accordance with subsection (c)(3). Based on medical record review, policy review, and interview, the facility failed to ensure all entries were authenticated and dated in 8 of 19 patient records reviewed (#N3, 4, 8, 9, 10, 14, 15, and 16).	S0748	The survey findings for tag S 748 included concerns with authentication and dating of consents and other documents. Malinda Wyatt, Director of Medical Records and Tara	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings included: 1. Review of the facility policy titled Charting Procedure, dated November 2001, indicated, ..."3. All charting entries shall be signed: first initial, last name, and title." Policy #1408, titled Persons Authorized to Record in Patient's Medical Record, dated 10/09, indicated under Special Instructions, ..."3. All entries shall be dated and authenticated by the person making the entry including professional initials." 2. The medical record for patient P3 indicated the Anesthesia PACU Standing Orders from 02/24/11 were signed by a nurse, but not dated or timed. 3. The medical record for patient P4 indicated 2 different consents from 12/10/10 with the space for date and time after, "I have personally explained to the patient or her representative, the information set forth in the above on:" left blank, but with a physician signature. 4. The medical record for patient P8 indicated physician admission orders with no date or time from the physician and no date, time, or signature by a nurse to indicate the orders were carried out.		McVay, Director of Nursing reviewed our current process and determined that education and monthly audits must be done. Each department is educating staff during their department meetings and a presentation will be given to the physicians during Primary Care and Surgery Sections. The audit findings will be reported to the Medical Record Committee and to the Quality Committee. Attachment A: Action Plan for documentation completeness and error correction Attachment B: Nursing Policy/Process Attachment C: Department Education Sign In sheets Attachment D: Monthly audit tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. The medical record for patient P9 indicated a surgical consent from 12/30/10 with the space for date and time after, "I have personally explained to the patient or her representative, the information set forth in the above on:" left blank, but with a physician signature. 6. The medical record for patient P10 indicated Anesthesia PACU Standing Orders from 03/16/11 with no date, time, or signature by a nurse to indicate the orders were carried out. 7. The medical record for patient P14 indicated a surgical consent from 11/01/10 with the space for date and time after, "I have personally explained to the patient or her representative, the information set forth in the above on:" left blank, but with a physician signature. 8. The medical record for patient P15 indicated a consent from 03/25/11 with the space for date and time after, "I have personally explained to the patient or her representative, the information set forth in the above on:" left blank, but with a physician signature. The record also had Pre-Op C-Section Anesthesia Orders and Anesthesia PACU Standing Orders with no date, time, or signature by a nurse to indicate the orders were carried out.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9. At 2:00 PM on 06/29/11, the medical record findings were confirmed by staff member N1. 9. The medical record for patient P16 indicated physician orders on the Emergency Department Order Sheet with no date or time for the medications ordered or for the physician or nurse signatures.			
S0952	410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on medical record review, policy review, and interview, the facility failed to ensure staff followed the policy for blood administration in 5 of 7 records reviewed of patients who had received blood transfusions (#P8, 10, 11, 13, and 15). Findings included: 1. Review of the facility policy titled	S0952	Tag S 952 survey findings gave Jeanette Huntoon, Chief Executive Nurse and Tara McVay, Director of Nursing an opportunity to review our blood administration process. In collaboration with Dr. Stark, Pathologist, the Blood and Blood Component Transfusion Procedure was reviewed and revised. The Blood Administration form was revised and a nursing competency was	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Blood and Blood Component Transfusion, dated April 2011, indicated under III. Procedure: ..."2. Take vital signs and record for baseline." It continued, ..."15. Record vital signs upon initiation, @15 minutes, 1 hour, and upon completion." The policy also indicated under X. Suspected Blood Reaction, ..."1. Check for reaction throughout procedure. a. Non Severe (allergic) reaction. ... 3. Fever (rise in temperature greater than 1 degree Centigrade or 2 degrees Fahrenheit). 2. If you suspect a reaction, stop the infusion immediately, turn on normal saline with new tubing. Notify the M.D. promptly. Notify Lab immediately. 2. The blood transfusion form for patient P8 indicated a transfusion was started at 1540 on 01/23/11 and the 15 minute vital signs were taken at 1550 and the one hour vitals were taken at 1650. 3. The blood transfusion form for patient P10 indicated a transfusion was started at 1502 on 03/16/11 and the 15 minute vital signs were taken at 1517 and the one hour vitals were taken at 1635. 4. One blood transfusion form for patient P11 indicated a transfusion was started at 1410 on 12/21/10 and the 15 minute vital signs were taken at 1429 and the one hour vitals were taken at 1517. Another blood		developed. Education is being completed will all clinical staff.The Blood Bank personnel perform a 100% audit the completion of the Blood Bank Issue/Transfusion form. The results are reported quarterly to the Lab Quality Assurance Committee. Attachment A: Procedure – Blood and Blood Component TransfusionAttachment B: Blood Administration formAttachment C: Competency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfusion was started at 1250 on 12/22/10 and the 15 minute vitals were taken at 1305 and the one hour vitals were taken at 1400, but that time was written over/changed. Yet another transfusion was started at 1520 on 12/22/10 and the 15 minute vitals were documented as 1510 and the one hour vitals were documented as 1555. 5. One blood transfusion form for patient P13 indicated a transfusion was started at 2220 on 02/24/11 and the 15 minute vital signs were taken at 2230 and the one hour vitals were taken at 2330. Another transfusion was started at 1100 on 02/25/11 and the temperature was documented as 97.9. The 15 minute temperature was 97.1 and the temperature at the completion was 100.0, an increase of more than 2 degrees Fahrenheit. The medical record failed to indicate any documentation regarding this change or any notification of the physician or the lab. 6. The blood transfusion form for patient P15 indicated a transfusion was started at 0640 on 03/26/11 and the 15 minute vital signs were taken at 0645 and the one hour vitals were taken at 0740. 7. At 2:00 PM on 06/29/11, staff member N1 confirmed the findings and indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff seem to be confused about the times for the vital signs and need reeducation.			
S1024	410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on observation, document review, and interview, the facility failed to ensure outdated medications were removed and medications were marked when opened to prevent outdated use in 3 of 3 anesthesia carts in the surgery department. Findings included: 1. During the tour of the surgical department, beginning at 1:10 PM on 06/28/11, and accompanied by staff members N1, N3, and N21, the following items were observed:	S1024	Tag S 1024 survey finding states, "the facility failed to ensure outdated medication were removed and medications were marked with opened to prevent outdated use…". The Chief Pharmacist has reviewed and revised our policies concerning outdated medications. Education is being performed with staff to ensure understanding of proper removal of outdated medications	08/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A. A 10 milliliter multidose vial of Neostigmine open, but not dated, in anesthesia cart #1. B. One ProAir inhaler with an expiration date of 03/2011 was loose in the drawer of anesthesia cart #2. C. One ProAir inhaler in the manufacturer's packaging with an expiration date of 05/2011 was in the drawer of anesthesia cart #2. D. Multidose vials of Amidate, Succinylcholine, Rocuranium bromide, and Glycopyrrolate were open, but not dated, in anesthesia cart #2. E. Multidose vials of Neostigmine, Glycopyrrolate, and Rocuranium bromide were open, but not dated, in anesthesia cart #3. 2. At 1:30 PM on 06/28/11, staff member N3 indicated multidose vials should be dated when opened and discarded after 30 days. He/she also indicated the only policy regarding this was #6710-039, Infection Control, Pharmaceutical Services which indicated, ..."6.0 Procedure: Multiple dose vials, The expiration date for multidose vials will be 30 days from the initial entry into the vial, providing that there is no obvious contamination and that normal precautions have been taken."		and marking of opened medications. A monthly audit will be performed and reported to Infection Control/Pharmacy & Therapeutics. Attachment A: Action Plan for Labeling Multidose vialsAttachment B: Policy 6710-015 page 9Attachment C: Policy 6710-039 page 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and interview, the facility failed to ensure exposed batteries had the appropriate eye washing station and replacing a directional exit sign that was previously damaged. Findings included: 1. At 10:15 AM on 6/27/2011, the diesel generator was inspected. The generator had 2 large 12 volt batteries sitting outside the generator exposed on a platform. The enclosed room had a wall mounted eye washing station with 1-32 ounce bottle of saline solution which can only provide 4 minutes of continuous eye flushing if acid was splashed into someone's eyes. Strong acid from batteries require an eye washing station that can provide 15 to 20 minutes of continuous flushing. The enclosed room could not provide the proper eye flushing if the acid was able to come in contact with someone's eyes.	A1118	Dave Brumett, Manager of Facility Services has reviewed the survey findings in tag A 1118 and has developed the plans below.1. The survey findings ask for an eyewash station near open batteries.The plan is to replace the batteries with "Maintenance Free" batteries. Maintenance free batteries (lead acid or alkaline) are sealed and do not require topping up with distilled water, it is not possible to add water or electrolyte to the cells and thus the potential for eye contact with electrolyte is essentially non-existent; therefore, there is no need to install an eyewash station.Attachment A: Work Order for placement of the maintenance free batteries shows they will be installed by August 26, 2011.2. They survey findings noted a damaged directional exit sign.The directional exit sign will be replaced.Attachment B: Work Order for replacement of the	08/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150072	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. At 2:00 PM on 6/27/2011, the Materials Management Department was toured. In the far back corner was a fire door that was observed with a fire exit sign above it. The sign could not be seen unless you were in the far rear of the building within 10 feet of the sign. There was no directional exit sign mounted on the ceiling directing flow of traffic to the rear fire exit in case of a quick evacuation. 3. At 2:15 PM on 6/27/2011, staff member #19 indicated the room had a directional fire exit sign leading traffic to the rear fire exit door. The staff member indicated the sign was knocked down and never was replaced.		damaged directional exit sign shows the sign will be replaced by August 26, 2011.	